# EXHIBIT "O" - Dyse Deposition

Joseph Papin

*vs.*

University of Mississippi Medical

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Deposition of:

KISHA DYSE

November 16, 2020

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Vol 01

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

JOSEPH PAPIN

PLAINTIFF

V. CIVIL ACTION NO. 3:17-CV-763-CWR-FKB

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER; DR. LOUANN WOODWARD, IN HER OFFICIAL CAPACITY; AND DR. T. MARK EARL, IN HIS INDIVIDUAL CAPACITY

DEFENDANTS

# DEPOSITION OF KISHA DYSE

Taken at the instance of the Plaintiff at via Zoom Teleconference, on Monday, November 16, 2020, beginning at 2:00 p.m.

REPORTED BY:

ROBIN G. BURWELL, CCR #1651

APPEARANCES:

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EXAMINATIONS



EXHIBITS

KISHA DYSE,

having been first duly sworn, was examined and testified as follows:

EXAMINATION BY MR. MORGAN:

**Q. If you could, please state your full name for the record?**

A. My name is Kisha, K-I-S-H-A, Lashawna, L-A-S-H-A-W-N-A, and my last name is Dyse, D-Y-S-E.

**Q. We met just a moment ago. But my name is Ryan Morgan, along with Jolie Pavlos on the screen there as well, we represent Joseph Papin in regards to a claim he has brought against the UMMC entities and others.**

**Is this your first deposition?**

A. No, sir.

**Q. How many other depositions have you given before, ballpark?**

A. I have had one before now.

**Q. Okay. What type of case did you have to give a deposition in?**

A. It was a case concerning a child that was injured in a behavioral health facility.

**Q. Ballpark, how many years ago was that?**

A. That was 20 -- I believe it was 2010.

Q. I'll go over it since it's been a little while for you, and I'm sure probably Tommy reiterated some of these grounds rules that lawyers always like to give at the beginning of depositions.

A. Yes, sir.

Q. Particularly true when we're doing it this way on Zoom is to make sure that we take turns responding. Let me ask my question and I have to let you, because I'm totally guilty of it myself, of letting you finish your full answer. That way Robin, the court reporter, can type out everything and know exactly who is saying what. Okay?

A. Yes, sir.

Q. Yes or nos are preferable to uh-huh (affirmative response) or huh-huh (negative response.) It happens every deposition and I'll just say hey, is that a yes or a no, just to make sure the record is totally clear. Okay?

A. Yes, sir.

Q. If I ask a question that just does not make sense to you, please ask me to rephrase. It does not offend me at all. You're an expert in this field, I'm not. So if something just doesn't

**make sense, let me know. Okay?**

A. Yes, sir, I will.

**Q. If you need a break at any point let me know as well. I usually break every hour give or take anyways to stretch our legs. But if you need one for some reason, no problem, just let me know.**

A. Okay. I will.

**Q. Other than the deposition that you were describing a moment ago, have you ever testified under oath in any other capacity?**

A. No, sir.

**Q. I have to ask this question -- two questions to each person, so I apologize in advance.**

A. Okay.

**Q. Number one is have you ever been convicted of a crime before?**

A. No, sir.

**Q. Number two is are you on any sort of medications or drugs that could impair your ability to remember facts and things that happened years ago?**

A. No, sir.

**Q. Makes it easy. Good. For this deposition I don't want to know any sort of**

**substance that you spoke about with Tommy, but I would assume you spoke with Tommy about this deposition; is that correct?**

MR. WHITFIELD: Ryan, we lost you for about 10 seconds there.

MR. MORGAN: Sorry, can you hear me now?

(Off the record discussion)

**Q. (By Mr. Morgan) Ms. Dyse, what I had asked you was, I don't want any substance of your conversation you had with Tommy, but I would assume you spoke with Tommy about this deposition; is that correct?**

A. Yes, sir.

**Q. How many times did you speak with Tommy about this deposition?**

A. One time.

**Q. And when was that?**

A. I don't remember the date.

**Q. Was it last week or before that?**

A. It was before last week.

**Q. Okay. Approximately how long was your conversation to prepare for the deposition?**

A. I would say approximately one hour.

**Q. Did you speak with anybody else besides Tommy regarding this deposition today?**

A. No, sir.

**Q. Did you review any documents to prepare for this deposition?**

A. Yes, sir.

**Q. What documents did you review?**

A. My charting.

**Q. Would that be the charting for the patient with the decubitus ulcer that we're going to be discussing?**

A. Yes, sir.

**Q. Any other documents that you reviewed besides those?**

A. No, sir.

**Q. A couple of kind of background questions, Ms. Dyse. Are you married?**

A. Yes, sir.

**Q. How long have you been married?**

A. I've been married for 19 years.

**Q. Do you have any children?**

A. Yes, I do.

**Q. How old are they and what are their genders?**

A. I have a 12-year old daughter and I have a 17-year old son.

**Q. Where do you live?**

A. I live in Brandon, Mississippi.

**Q. If you could, walk me through your education background starting with high school up through present?**

A. Okay. So I graduated from high school in 1994 from Wingfield High School. I then attended Hinds Community College. I obtained my associate's degree in nursing. I went back to school and obtained my bachelor's degree in nursing from Alcorn State University. And I received my -- I have two wound care certifications. My first certification I obtained in 2012, and my second wound care certification I received in 2016.

**Q. Do you have any master's degrees?**

A. No, sir.

**Q. For the first wound care certification in 2012, if you could, just walk me through the process to get that certification?**

A. That process is I went to a five-day course -- a five-day curriculum and I sat for a national exam.

**Q. And is there a name for that certification?**

A. It's just called wound care certified.

Yes, sir.

**Q. What about the 2016 one?**

A. That one is a wound ostomy and continence nurse. That one I went to nine months of school and then I had clinicals, and after that I had to take a national exam.

**Q. When you say nine months of school, was that a certain number of hours per week or are you --**

A. Actually, the school is a three-month course for wound certification. It's a three-month course for ostomy and it's a three-month course for continence. But when you get the certification, they're all combined together.

**Q. But during the regular schooling time, is it an everyday schooling type thing?**

A. It's online so you don't go every day. You just have to have your casework finished by a certain amount of time during that week.

**Q. I'm trying to get sort of a flavor of how rigorous this is. Is this something that you're doing 10 hours a week to study for, more or less?**

A. I wouldn't say 10 hours a week. I would

say -- I'm not sure, sir. That's been awhile ago so I'm not sure how often I studied.

**Q. Fair to say, though, you were doing this studying in addition to your regular full time job?**

A. Yes. Yes, sir.

**Q. So it wasn't like you stopped working, went to the schooling for nine months and then came back?**

A. No, sir, I worked while I was employed -- I worked while I was in school.

**Q. Do you have any sort of continuing education that you have to comply with?**

A. No, sir.

**Q. So, we have your AA degree, your BA degree, the two wound care certificates. Any other designations by your name or certifications that you have received?**

A. Well, I'm continence certified and ostomy certified.

**Q. So those are two separate ones from the two wound care ones?**

A. Yes, sir.

**Q. So, in total you would have four certifications?**

A. Yes, sir.

**Q. What is ostomy?**

A. Ostomy is people who have ileostomies, colostomies or urostomies. We take care of those. That's when a person has a diverting surgery. So, say for instance the person would have a cancer or something and they are no longer able to urinate or defecate through the anus or the urinary organs, so that person would have a stoma placed on their abdomen and that's where they would defecate or urinate.

**Q. For the record, what is wound care? When you say wound care, what do you mean by that?**

A. Can you clarify that for me?

**Q. Yes. You were talking about you were having wound care certificates and were talking about that you're a wound care nurse and all that. Just generally speaking, what does wound care mean?**

A. Wound care means an opening in the skin, a break in the skin, and from there we would take care of that or write recommendations for it. I guess you would say any break in the skin that's not normal. Your skin has broken down in some way.

**Q. I know what incontinence is, but can you just explain that for the record. I just want to make sure you and I are on the same page about things?**

A. Yes, sir. Incontinence is when a person can't control their bladder or bowels.

**Q. When you're working -- let me clarify, are you still currently employed by UMMC?**

A. Yes, sir.

**Q. What is your position?**

A. I'm an internal stomal therapist.

**Q. What does that mean?**

A. That's a wound care nurse, a nurse that specializes in wounds, ostomies and continence.

**Q. How long, ballpark, have you been in that position?**

A. I started at UMC in February of 2016. I stopped working there in 2018, and I just started back October 5th of this year. So October 5th, 2020.

**Q. What was the reason for the gap in employment with UMC?**

A. I took another position, a consulting position at a nursing home.

**Q. So the -- were you in the same position**

**the first two years from 2016 to 2018 that you are now?**

A. Yes, sir.

**Q. A moment ago you stated that there was no continuing education that you have to comply with for your license or anything like that. Is there any sort of like established treatises or textbook or literature that you would consider or that the wound care community considers to be the sort of gold standard?**

A. Yes, sir. The certification that I have, the WOCN is the gold standard, and you have to recertify for that every five years. So I'm actually in the process of recertifying for that now.

**Q. That would be the one you got in 2016?**

A. Yes, sir.

**Q. Generally speaking, what is the recertification process like?**

A. You have to, of course, study. And then once you've completed your studying and you feel like you're ready to take the examination, you take it on your own terms. You have a certain amount of time to take it and you pay for your test and you sit for that national exam. It's

pretty much self-study.

**Q. Did you work in any capacity for UMC prior to February '16, like a different position or anything like that?**

A. No, sir.

**Q. If you could, walk me through your job history prior to February '16, sort of kind of going backwards?**

A. Okay. Let's see. As I said I was -- you want me to go backwards? So I'll say before coming to UMC I worked at Baylor All Saints in Fort Worth, Texas as a wound ostomy nurse. Before that, I worked at Select Medical Center in Texas. I was a ICU/floor nurse. Before that, I worked at Crossgates. It's now called Merit Health. I worked on the burn unit as a staff nurse. Before that, I worked at Brentwood, I think it was called Behavioral Health, as a staff nurse. And before that, I worked at Baptist Hospital as a staff nurse.

**Q. Ballpark, when did you work for -- what was the first one you said, you said it was Baylor, Texas?**

A. Baylor All Saints in Fort Worth, Texas. Yes, sir.

**Q. How long did you work there, ballpark?**

A. I worked there from 2014 up until I started here at UMC.

**Q. What about Select Medical?**

A. I worked at Select Medical from 2012 to 2014.

**Q. And about Merit Health?**

A. Merit Health I worked from 2010 to 2012.

**Q. And Brentwood Behavioral?**

A. Yes, sir, that was 2009 to 2010.

**Q. And then Baptist Hospital?**

A. That was 2008 to 2009.

**Q. What was the nursing home that you said you took the consulting position with?**

A. I worked at -- it's called Pine Forest Nursing and Rehab and it's in Jackson, Mississippi.

**Q. If you could describe to me -- let me ask it a different way. Who do you report to?**

A. I report to a nurse manager and her name is -- let me think, her name has changed. It's Mary Katy Melvin.

**Q. What do you call yourself? Do you call yourself a wound care nurse? What terminology do you use?**

A. We call ourselves wound care nurses, but according to the hospital we're internal stomal therapists.

**Q. How many wound care nurses are there at one time at the hospital?**

A. We have five now.

**Q. Is that typical when you were there in 2016 and 2018?**

A. In 2016, we had between three and two depending on if somebody left or...

**Q. In 2016, did you also report to a nurse manager?**

A. I did but it was a different nurse manager. Her name in 2016 was Lee Anne Lufkin.

**Q. I've seen some references in the record to a Wound Care Center.**

A. Yes. Yes, sir.

**Q. What is the Wound Care Center?**

A. It's in the pavilion. It is an outpatient clinic.

**Q. Would you also work in that facility at times?**

A. No, sir.

**Q. Is it different nurses work there?**

A. Yes, sir, there are different nurses

that work there.

**Q. So the two to three in 2016 and around five or so now would be working in the inpatient hospital side of things?**

A. Yes, sir, that's right.

**Q. How do you get assigned patients?**

A. We receive wound care consults via Epic.

**Q. For the record, what is Epic?**

A. Epic is our medical records computer system where we do our documentation and that type of thing.

**Q. How does it work in real life, in practice? Is it just a rotating basis that you just rotate who receives which consult or is there a certain other way the work is divided up?**

A. Well, different physicians or nurses or floors would put in a wound care consultation and it's a rotating of whoever is available will see that consult. We work by the one that's next in line per se.

**Q. Okay. Is there 24-hour coverage with the wound care consults or is it certain hours typically you're working?**

A. No, sir, it's not 24-hour coverage. Our coverage is between 8:00 and 4:30, Monday through

Friday.

**Q. A consult is entered, as an example, noon on Saturday. It's going to wait until Monday morning when people come back to work?**

A. Yes, sir.

**Q. For the nurse manager, do you know who the nurse manager reports to?**

A. No, sir, I'm not sure.

**Q. But as far as like giving feedback or discussing work issues, Mary would currently be the nurse manager you would go to?**

A. Yes, sir.

**Q. Is there a doctor that oversees the group or no?**

A. No, sir.

**Q. Any sort of semi-scheduled meetings -- and by semi-scheduled, I mean do you have like a weekly department meeting or monthly meeting or anything like that?**

A. No, sir.

**Q. What are the most common types of wounds that you're treating?**

A. I'm sorry, sir, I couldn't hear you.

**Q. I'm sorry. What are the most common type of wounds that you see when you're treating**

**patients?**

A. The most common type, I would say pressure ulcers, venous stasis ulcers, sheer friction, incontinence associated dermatitis, cancer wounds, trauma wounds. Those are the most common.

**Q. What is a pressure ulcer?**

A. A pressure ulcer is a wound that develops when a sustained amount of pressure has caused an injury. The tissue has lost blood flow and so a wound will develop.

**Q. It could be like a bed sore, is another common name?**

A. Yes, sir, bed sore is another common name.

**Q. If you could, walk me through -- and I know every patient is different -- but your typical routine when you first see a patient and you've been given a consult?**

A. Okay. We will -- Epic will alert us that we have a consult. I will go to that patient's room, I will assess that patient's wound and I will write treatment recommendations based on the assessment that I just had with that patient. And I would enter those wound care

recommendations into the computer.

**Q. For your treatment recommendations, do those have to be approved by a doctor?**

A. No, sir.

**Q. Is anybody else involved besides you in the plan of care when you're treating the wounds?**

A. I'm sorry, I don't understand your question.

**Q. Do you ever typically consult with anybody else when you are sort of developing this plan of care? Like, do you talk to the attending physician or anybody else who may be relevant or is it really just on you?**

A. I just write a wound care recommendation.

**Q. Are there times where you're, I don't want to say stumped by one, but is it maybe a more difficult one and you feel the need to consult with the attending or someone else?**

A. I don't usually consult with the attending over the wounds. When a wound is -- when I see a wound and I write a recommendation, that's just my recommendation for the wound.

**Q. Well, when you say a recommendation, to me that implies somebody could not follow the**

**recommendation?**

A. That's right. Yes, sir.

**Q. So who makes the decision then to follow that recommendation or not?**

A. I'm not sure who makes that decision. I just put the recommendation as far as I see fit in the computer, and if the doctor does not want to comply with that he can delete my recommendation and put what he sees fit in the computer. He or she.

**Q. So once you put it in there you really don't see it anymore. You're not sure what happens subsequently unless you keep revisiting the patient?**

A. Yes.

**Q. And after you've been assigned a patient, is there any sort of standard like you go see that patient daily or any sort of routine that you use to treat the patient?**

A. No, sir. What happens is once I've seen the patient we are reconsulted if the wound deteriorates or if the nurse or physician needs me to look at it again.

**Q. That would be coming from a consult, a new consult?**

A. Yes, sir.

**Q. In a perfect world you come by, do your consult, make your recommendations and then you would not have to see that patient again?**

A. That's right, yes, sir.

**Q. Ballpark, how often does that happen where it's just a one consult and done? Is that the majority of patients?**

A. I don't know. I don't know. We see so many patients, I'm not sure.

**Q. When you get a request for a second consult --**

A. Yes, sir.

**Q. -- is there any sort of typical timeframe which that occurs; is it a couple of days later, could it be any point later?**

A. It could be any point later. There's no set way somebody consults. It just varies depending on the patient.

**Q. Do you ever consult with first year residents on treatment?**

A. No, sir.

**Q. Do you remember Dr. Papin?**

A. No, sir.

**Q. So if you saw a picture of him -- you**

**may recognize his face but you don't have an independent recollection in your head right now of who he is?**

A. No, sir. I see so many, no, sir, I wouldn't know him.

**Q. I know you said you've reviewed the records for this case. Do you recall this situation?**

A. I do recall that patient, yes, sir.

**Q. Do you recall interacting with any residents during that --**

A. I do not recall interacting with any residents.

**Q. Would you agree with me that your role as the wound care nurse, you had more experience diagnosing and treating wounds than a first year resident?**

MR. WHITFIELD: Object to the form.

THE WITNESS: I don't know that.

MR. WHITFIELD: I'm sorry, you can answer.

THE WITNESS: No, sir, I don't know.

**Q. (By Mr. Morgan) But fair to say that the hospital has designated you as the wound care nurse as the go-to medical treater for those**

**wounds?**

A. Well, the hospital had designated me to write treatment recommendations, and that's what I do is write the recommendations.

**Q. You're designated -- I'm sorry. I apologize. The hospital designates you as the first line of defense so to speak to diagnose and make recommendations for those wounds?**

A. We don't diagnose the wounds but we do make recommendations. As a nurse I can't diagnose.

**Q. What do you mean by that? Can you expand on that a little bit?**

A. Yes, sir. As a nurse I can't specifically say -- diagnose a wound. I can put in my recommendations and I can also say based on what I see that the wound is determined -- it formed a certain way. But I can't say for certain that it is one thing or another because I can't diagnose it.

**Q. Is it fair to say -- correct me if I'm wrong, but is it fair to say when you're putting in your notes you can write down what you believe it is but it's not an official diagnosis?**

A. Yes, sir, based on the evidence of what

I've seen I can say that this wound was developed through pressure.

**Q. But A doctor could look at it and disagree with you?**

A. I'm so sorry, I didn't hear you.

**Q. But a doctor could come in and look at it and disagree with you?**

A. Yes, yes, sir.

**Q. Could any residents come in and disagree with you?**

A. I'm not sure.

**Q. When you're making those treatment recommendations -- I just want to clarify something, you sort of touched on this. I know you said you write them into the computer system, correct?**

A. Yes, sir.

**Q. But do you also talk to the doctors, typically, about those treatment options?**

A. No, sir.

**Q. It's just writing, that way there's a written record of it?**

A. Yes, sir.

**Q. Could you also start those treatments on your own?**

A. No, sir. I don't start the treatments, the nurses start the treatments.

**Q. So if you're looking at a wound, you say hey, we need to start this process, the nurses that are there could actually do it?**

A. Yes, sir.

**Q. They don't have to wait for a doctor to say I approve it, they would just go ahead and start that treatment you recommended?**

A. Yes, sir.

**Q. Do you write orders?**

A. Do I write orders?

**Q. Yes.**

A. No, I only write wound care recommendations.

**Q. Do you know what an intern is?**

A. No, sir, I don't know their qualifications or anything. I hear the name, but I don't know them from a resident. No, sir.

**Q. Intern -- we've seen some usage of the word intern to mean resident. So a resident or an intern, do you know if a resident can write treatment options for a wound care patient?**

A. I don't know if they can.

**Q. Do you know if a resident can make an**

**independent diagnosis of a wound care patient?**

A. I don't know.

**Q. Have you ever seen that happen?**

A. I have not seen that happen.

**Q. Have you seen where an attending physician writes a recommendation for a wound care patient?**

A. I've not seen an attending write a recommendation. I'm not saying it didn't happen, but I have not seen that.

**Q. That was going to be my next question. Can you recall any times where an attending physician has disagreed with your recommended treatment?**

A. I don't know. I can't remember if one has or has not. I just don't know.

**Q. But as we sit here right now you can't think of a specific time where a doctor -- and you found out about it -- where a doctor disagreed with you and ordered different treatment?**

A. No, sir.

**Q. Do any positions report to you?**

A. I'm sorry, I didn't hear you.

**Q. Do any positions, any employees report to you?**

A. No, sir.

**Q. When -- I want to follow up on a minute ago when we were talking about how you said that once you are requested for a consult you do the consult and then you don't go back to visit the patient unless specifically requested, correct?**

A. Yes, sir.

**Q. So there's never a time where maybe hey, I need to just come back every day for a few days to keep checking up on this patient?**

A. No, that would have to be put in a consult. We work on consults only.

**Q. Okay. You testified a moment ago that you do remember this particular patient. What do you recall about this patient?**

A. I recall that he was paralyzed, I believe, from a gunshot wound.

**Q. Do you recall anything else about like course of treatment or anything?**

A. I do remember his course of treatment.

**Q. What do you remember about it?**

A. I remember that he -- that I initially saw him and I believe he had a small wound and then he ended up developing a pressure ulcer.

**Q. I'm going to pull up an exhibit here.**

MR. MORGAN: Y'all have a preference if I do a share screen or drop it in the chat? Doesn't matter to me, I can do both.

MR. WHITFIELD: Doesn't make any difference. Just let me know which one you want to do because I need to change seats and manipulate the computer.

MR. MORGAN: Okay. I'll do a share screen.

**Q. (By Mr. Morgan) Ms. Dyse, do you see this record on the screen?**

A. Yes, sir, I see it.

**Q. We will mark this as Exhibit No. 1 for this deposition.**

A. Yes, sir.

(Exhibit 1 marked for identification.)

**Q. (By Mr. Morgan) You can see my mouse moving, can't you?**

A. Yes, sir, I can.

**Q. Great. This looks like, just to kind of get our bearings and all this, a consult was done on November 15th, 2016 at 0900 hours which would be 9:00 a.m.; is that correct?**

A. Yes, sir, that's correct.

**Q. And this looks like this was done by a**

**different wound nurse than you, correct?**

A. That's correct.

**Q. Do you remember Kelly Pennock?**

A. Yes, I do remember Kelly.

**Q. Does she still work there or no longer?**

A. She does work there.

**Q. Would she be another wound nurse on basically the same equivalent level as you?**

A. Yes, sir.

**Q. And so looks like here it talks about how a wound care consult was ordered by Theresa Robertson. Do you see that?**

A. Yes, sir, I do.

**Q. Who is Dr. Robertson?**

A. I don't know.

**Q. This would follow what you described earlier about the only way a wound nurse gets a call is if a consult is ordered by somebody?**

A. Yes, sir.

**Q. And I see where it says here that this patient was high risk for pressure ulcer?**

A. Yes, sir.

**Q. Do you know why they would be high risk?**

A. Yes, sir.

**Q. Why is that?**

A. Because he was paralyzed. And I believe he was incontinent as well.

**Q. And fair to say for somebody who is paralyzed because they're typically immobile and sitting on the same spots, that can lead to pressure ulcers?**

A. Yes, sir.

**Q. It says here for the recommendation, pressure ulcer risk/management order set. Do you see that?**

A. Yes, sir, I do.

**Q. Is that sort of a standard recommended treatment?**

A. Yes, sir, we have a protocol in place for pressure ulcers.

**Q. What does this mean to you right there, that order set?**

A. That means that just as she has listed there we will reposition the patient every two hours -- well, we wouldn't, but the nurses would on the floor reposition the person every two hours. He would have perineal care. We would support his bony prominence and also apply incontinence cream to protect his skin.

**Q. I notice some of these, like number one**

**and five, are bolded whereas the others are not bolded. Is there any reason for that that you know of?**

A. I'm not sure why she bolded them.

**Q. She would have had to have physically hit Control-B to bold it?**

A. I'm not sure, sir. Yes, she would have to, you know, put the Control-B to make it bolded, but I'm not sure why she did.

**Q. Do you yourself ever bold certain instructions?**

A. I don't know.

**Q. Some people do and some people don't. I was just trying to see if that's something that you normally --**

A. I don't know.

**Q. Now on the bottom here it says monitor and notify MD/NP. Would that stand for a doctor or a nurse practitioner?**

A. Yes, sir.

**Q. And then what does the WOCN stand for?**

A. That's our certification. It's wound ostomy and continence nurse.

**Q. That would be the -- currently the five back -- back in 2016 the two or three nurses?**

A. Yes, sir.

**Q. So if they were going to notify the wound care team, that would be, again, that consult we've been describing?**

A. Yes, sir.

**Q. Does UMC have an ulcer prevention program?**

A. We have a pressure ulcer prevention protocol, yes, sir.

**Q. What is that protocol?**

A. It's like what Kelly had listed there. It lets the nurses know if the patient is high risk, certain things to do. That is to turn the patient, that is to protect the skin with some form of moisture barrier cream, that's to elevate the prominences, and that's to possibly elevate the feet with heel protected boots.

**Q. Is this one through six here, is that kind of the standard pressure protocol?**

A. It's not UMC standard protocol, but it is written in her own way. So, yes, sir, I guess you could say it's the protocol.

**Q. Is there somewhere in writing where that standard UMC protocol would be written?**

A. Yes, sir.

**Q. Where would that be?**

A. It's under a pressure ulcer order set. You can put in pressure in Epic and it will pull down a whole list of order sets and you would click on it.

**Q. What is staging a wound?**

A. Staging is determining the depth of tissue damage to the wound. And that's only done with pressure ulcers.

**Q. Can you stage a wound?**

A. Yes, sir.

**Q. Is that considered different than diagnosing the wound?**

A. Yes, sir.

**Q. I guess I want to make sure we're on the same page here. When I say the word diagnose and you're saying you can't do that, what does that mean to you to diagnose?**

A. That means that I have assigned a medical diagnosis to a patient with -- the difference is with a wound, I can look at that wound and determine that most likely it occurred through pressure, and I do have the ability with my certification to stage a pressure ulcer.

**Q. What is a decubitus ulcer?**

A. It's another way of saying a pressure ulcer. A wound that has occurred from sustained pressure between the bone and another surface.

**Q. So a decubitus ulcer is a little bit fancier terminology for a pressure ulcer?**

A. Yes, sir.

**Q. Are pressure ulcers preventable?**

A. Are they preventable?

**Q. Yes.**

A. In some cases they are, yes, sir. In some cases they are not.

**Q. How would it be not preventable? What are some examples?**

A. Some examples would be if a person is extremely compromised, say for instance that patient has no blood flow to that area or if the person is too unstable to turn, that would be an example where you couldn't avoid a pressure ulcer.

**Q. I'm going to share with you what we're going to mark as Exhibit 2.**

(Exhibit 2 marked for identification.)

**Q. (By Mr. Morgan) This was a consult done by you here?**

A. Yes, sir.

**Q. On November 30th, 2016, looks about 4:30**

**in the afternoon?**

A. Yes, sir.

**Q. Is this -- when you were talking about records you were reviewing earlier, is this one of the records where you were tried reviewing?**

A. Yes, sir.

**Q. It looks like here, again, Dr. Robertson had ordered a second consult for this patient; is that accurate?**

A. I'm not sure if that was a second consult, but it's definitely one of the consults.

**Q. This one says here a consult by Dr. Robertson at November 30th?**

A. Yes, sir.

**Q. Morning. Go back to Exhibit 1, it looks like Dr. Robertson on November 14th. Do you see that?**

A. Yes, sir.

**Q. So it looks like to me, but correct me if I'm wrong, this is a new second consult?**

A. Yes, sir.

**Q. Now it has this number here starting with 941. Does that mean anything to you?**

A. No, sir, I don't know what that means.

**Q. I didn't know if there was like -- is**

**that a further record that might describe this situation?**

A. I'm not sure.

**Q. When you get the requested consult, does it ever tell you why or it just says flat out consult and then you kind of have to figure it out yourself?**

A. Sometimes the consults will say why to see the patient.

**Q. Fair to say this one does not or you wouldn't be able to tell from this record whether it did?**

A. I just can't tell from that record.

**Q. So for here in this situation for some reason Dr. Robertson ordered a second consult but you can't tell from this record why that was ordered?**

A. That's right, yes, sir.

**Q. It looks like in this situation here, it looks like you -- I'm going to say the word diagnose, but I don't want you to say you don't diagnose. What would you call it here, your sentence that you says he has a partial thickness abrasion. Is that a diagnosis or you're just kind of stating a fact?**

A. I'm just stating what I see.

**Q. Okay. When you say a partial thickness abrasion, put that in layman's terms for us?**

A. That means that the epidermis and the top portion of the dermis has sluffed away but it hasn't reached any deeper levels of the tissue like the subcutaneous tissue.

**Q. So when you say a partial thickness abrasion, is that different than a pressure ulcer?**

A. Yes. Yes, sir, it is.

**Q. Are there similarities between the two?**

A. They can look the same but the tissue would behave differently.

**Q. In what way?**

A. With an abrasion I could do a test called a blanching where I would press the tissue and the tissue would turn white and from white it will turn back pink. That will let me know that the blood supply is intact. So that would not be a pressure ulcer.

**Q. Do you know if you did that type of examination here for this -- on this date?**

A. Yes, I would do that. I know I did that because I would have to do that to determine that it was not pressure.

**Q. You wouldn't have entered that into the note because that's just a normal practice you have to do?**

A. Yes, that's just normal.

**Q. Is it ever difficult to tell between those two things?**

A. I'm sorry, sir, I didn't hear it.

**Q. Is it ever difficult to tell between those two, an abrasion or a pressure ulcer?**

A. Yes, sometime it is difficult to tell. But we blanch the tissue and that helps us to determine if it's pressure related or not.

**Q. When you say blanch the tissue, is that the process you were describing?**

A. Yes, sir, that's where you press the tissue and look for blood flow to fill the wound bed.

**Q. Now, in this course of treatment here that you were recommending.**

A. Yes, sir.

**Q. If your test had shown that it was a pressure ulcer, would you have given a different treatment diagnosis or recommendation?**

A. In this case, no, that would -- I would not have done anything different.

**Q. Why not? I'm just trying to understand why.**

A. Because he has -- he's already on a pressure redistribution mattress. All of our patients are. And the protocol for that depth of a wound is the zinc oxide, and I can tell that that's on him because I can see it in the picture.

**Q. So, from a pressure ulcer perspective, you were already -- and I say you, meaning the hospital and the team, were already doing what is typically used to treat that?**

A. Yes, sir.

**Q. There was nothing else, I guess, to be done at that point?**

A. No, sir, at that point, no.

MR. MORGAN: For the record, for Robin and for Tommy, what's easier for you guys, do you want me to just email you these exhibits at the end of the deposition, drop them into the chat at the end?

COURT REPORTER: Email them will probably be better.

MR. WHITFIELD: Email is fine.

MR. MORGAN: Okay. That works for me. I was going to go through like Bates stamps and

all that, but I'll just send them to you by email.

We're going to mark Exhibit No. 3 here.

(Exhibit 3 marked for identification.)

**Q. (By Mr. Morgan) I'm going to scroll down here because it starts here at the bottom, where you can see it looks another consult by you on December 9th. Do you see that?**

A. Yes, sir, I see it.

**Q. And this would have been, it looks like, again, Dr. Robertson ordered a third consult on this?**

A. Yes, sir.

**Q. And you came, it looks like, the next day to do the review?**

A. Yes, sir.

**Q. But fair to say, again, I don't see any reason on this record about why Dr. Robertson ordered the consult?**

A. No, I can't tell from that screen.

**Q. If a reason was listed, would it normally be on a screen like this?**

A. The reason is usually listed under an order set page under summaries in Epic.

**Q. Are these records we're looking at here, is this part of the Epic system? Do these look**

**familiar to you as far as format and structure?**

A. Well, the heading looks different. In Epic I think I will only see the pictures and the part that I had written.

**Q. Do you remember this consult here and what you did here?**

A. Yes, sir, I do.

**Q. Walk through what you are seeing on this would be, I guess, the second time you had seen this patient?**

A. Okay. The second time I see him compared to the first time, I can see that he has eschar on the wound bed.

**Q. What is eschar?**

A. Eschar is sometimes moist or dry necrotic tissue.

**Q. I hate to keep asking you what does this mean, what does this mean, but I'm just doing this to make sure we're on the same page and one day this may be read to a jury. But when you say necrotic, what does that mean?**

A. It means it's non-living tissue or dead tissue.

**Q. Okay. I interrupted you. Keep going. I'm sorry.**

A. I was done. I said it's necrotic tissue or dead tissue.

**Q. And what did you recommend here at this point?**

A. I recommended Santyl enzymatic debrider.

**Q. And what are those?**

A. Santyl is an enzyme that eats away at the necrotic tissue but leaves the intact tissue, leaves the healthy tissue alone. It will only attack the necrotic tissue.

**Q. At this point, it looks like you've assessed that it's not an abrasion but an unstageable pressure ulcer. Do you see that?**

A. Yes, sir.

**Q. When you say an unstageable pressure ulcer, what does that mean?**

A. That means that I am unable to fully see the wound bed. What I see is the eschar is covering most of the wound so I can't tell the depth of the wound.

**Q. I guess, how do you determine the depths of the wounds?**

A. You can't tell until the eschar is fully removed.

**Q. Is that when you can peel it back to**

**look at it?**

A. I can't peel it back, a physician would. But, yes, sir, when that eschar is gone you can see the true depth of the wound.

**Q. I believe you said a physician can do that?**

A. A physician, yes. As a nurse I can't sharp debris, which means I can't take a scalpel or anything sharp to remove that eschar. Only a physician can do that.

**Q. For an unstageable pressure ulcer like this, the recommendations that you've made here, are those kind of a generally accepted treatment options or are these something that's kind of out of the norm?**

A. It's generally accepted.

**Q. Were there other options that you could have given but chose not to?**

A. No, sir.

**Q. From your perspective this is a pretty standard assessment in treatment option that you diagnose?**

A. Yes, sir.

**Q. When I say diagnose, is there a difference in your mind between a nurse diagnosis**

**and a medical diagnosis?**

A. Yes. I just know that as a nurse we can't diagnose. We can say what we see, but we can't diagnose it or call something officially a medical diagnosis. We can just state what we see.

**Q. Would that be what you see here where it says assessment?**

A. Yes, sir.

**Q. It talks about for number four, change the dressing once daily. Do you see that?**

A. Yes, sir, I do.

**Q. Fair to say that wouldn't be your job to do, correct?**

A. No, sir, I would not do that.

**Q. Who typically would be the ones doing that?**

A. The staff nurse or the nurse that is assigned to that patient.

**Q. Do physicians typically change the dressings or it's more so the nurses?**

A. I'm not sure.

**Q. I see on your -- I'll call it your signature block here.**

A. Yes, sir.

**Q. What does the WCC -- is that the 2012**

**certification we were talking about?**

A. Yes, sir, that's wound care certified.

**Q. And then the CWOCN one would be the 2016 certifications?**

A. Yes, sir.

**Q. For the record, RN is registered nurse. But you're an RN?**

A. Yes, sir.

**Q. It looks like on this situation here for this note, it looks like your date of service on December 9th was 1340, which would be 1:40 in the afternoon, correct?**

A. Yes, sir.

**Q. And it looks like going down to the next page, did you come back at 1900 hours, which would be 7 p.m.?**

A. I don't remember.

**Q. Because it looks like two different entries to me. So my question was whether you saw this patient twice that day or is this just a followup note that you added into the Epic system?**

A. It looks like I may have been reconsulted for that patient and I put in a note letting them know that I had already seen the patient.

**Q. So do you remember if you went back and saw the patient again or are you just responding to that consult with you had already seen them today?**

A. I was responding by letting whoever put that consult in that he had already been seen.

**Q. Okay. We've been going for almost an hour. Let's just take a quick two-minute break.**

(Off the record.)

**Q. (By Mr. Morgan) I'm going to mark Exhibit No. 4.**

(Exhibit 4 marked for identification.)

**Q. (By Mr. Morgan) This is a consult encounter note for December 22nd by you. It looks like another wound care consult by Dr. Robertson. Do you see that?**

A. Yes, sir, I do.

**Q. If you could, walk me through -- walk me through this one when you came back. I guess this would have been your third visit to this patient?**

A. Yes, sir. You said walk you through it?

**Q. Yes. What you saw and what you were doing?**

A. I saw he still has his black eschar. The wound has increased in size. 90 percent

eschar, 10 percent pink viable tissue. He has serosanguinous drainage. A small amount. It's irregular shaped and the wound edges are open and macerated. I recommend to continue the use of the Santyl.

**Q. When you say the wound edges are irregular and there's macerated edges, what does that mean to you?**

A. Irregular means the shape isn't -- it isn't a circle or a complete circle or a square. It kind of has an irregular outline to the shape of the wound. And then macerated means that it's moist. It's just another name for something that's moist.

**Q. And your recommendation to the continued use of Santyl --**

A. Yes, sir.

**Q. -- was that, again -- my question from before, is that the sort of standard response to this situation or are there other courses of treatment you could have chosen?**

A. At that moment when I looked at it, Santyl was the best option.

**Q. At this point it was still an unstageable one, because you testified you could**

**not use a scalpel to peel back the eschar?**

A. Yes, sir, that's correct.

**Q. Could you have asked somebody to do it?**

A. Could I ask someone to debride it?

**Q. Yes, so that you could stage it?**

A. Well, when I looked at it I saw what I saw and I felt like Santyl was appropriate.

**Q. But if for some reason you saw the scab or the eschar, could you have requested somebody to peel that back to get a better look at it?**

A. Well, the Santyl is working. From what I see, the Santyl is working appropriately at that moment that I looked at it. It looks like it was working appropriately.

**Q. So this exam by you would have been done at 10:59 a.m.?**

A. Yes, sir.

**Q. So when it says date of service, that's literally the time when you were there with the patient doing your treatment?**

A. Yes, sir.

**Q. The pressure ulcer is now four-and-a-half centimeters by five.**

A. Yes, sir.

**Q. How do you measure that?**

A. You measure length. Which was 4.5-centimeters and length would be basically the length of -- the shape of the spine. So from head to toe would be 4.5. And 5.0 would be width or across the wound.

**Q. During this exam would you have done that same test you had described earlier with the pressure on it?**

A. No, sir, you can't do that with eschar.

**Q. So you did that with -- the first time you saw this patient, correct?**

A. Yes, sir, because the wound bed wasn't covered by eschar.

**Q. Would you have done it at the second examination? If you need to go back to that note I can, on Exhibit 3?**

A. No, because the eschar is what's used to stage it at that point.

**Q. What do you mean by that?**

A. The wound is beyond the depth of the dermis so the blanching wouldn't be appropriate. I could see the eschar on the wound bed which lets me know that the wound is unstageable.

**Q. From the second time to the third time, obviously, this ulcer is getting bigger, fair to**

**say?**

A. Yes, it is bigger.

**Q. And the eschar is getting to be larger?**

A. Yes, sir.

**Q. Is there a point in time where when you're looking at a patient like this where -- maybe emergency is the right word. Right, when you're looking at something and you say my goodness, this is really, really bad, this is an emergency, we need a doctor in here right away. Has that ever happened?**

A. It has happened before, yes, sir.

**Q. A situation like this here, what would have needed to have occurred for you to kind of take that course of action?**

A. What would make me take that action would be if the eschar was what we call unstable. That means that the eschar is lifted up and if the wound was showing signs of infection. And that would require that a physician would immediately get involved.

**Q. I was going to ask because I -- you were saying you couldn't do that yourself?**

A. No, I cannot remove the eschar, no, sir.

**Q. So then what would cause you to request**

**a physician to do that?**

A. If the wound was showing signs of infection or if the eschar was unstable then I would request that a physician would see it.

**Q. So in this situation here on Exhibit 4, this situation did not meet those two options?**

A. From my standpoint, no, sir.

**Q. Have you ever heard the term grossly necrotic?**

A. Grossly necrotic?

**Q. Yes.**

A. No, sir.

**Q. We talked about what necrotic was earlier. Would you consider this at this point here to be a necrotic wound?**

A. It is a necrotic wound, yes, sir.

**Q. You checked for whether the wound smells? I've seen some documents referring to it as foul smelling.**

A. Yes.

**Q. Is it something as kind of a routine check?**

A. Yes, sir.

**Q. So you would have checked it in this situation for Exhibit 4, correct?**

A. Yes, I would have.

**Q. And if it was foul smelling I would imagine you would notate that in the record?**

A. Yes.

**Q. But you did not here?**

A. No, sir, I did not.

**Q. Walk me through how it kind of works in real life. I know you said earlier that -- I don't want to put words in your mouth so correct me if I'm wrong here. That typically you would make your assessment, but you're not like assessing it with an attending physician there. You enter your treatment in and the attending physician see it there later. But are there other people in the room with you, typically, who are there watching your treatment that you're talking with and giving your thoughts to?**

A. No, sir.

**Q. It's usually just you?**

A. Yes, sir, or maybe a nurse helping me position the patient. But I'm the only one making the decision.

**Q. Are there ever times where you leave after doing a treatment like this with a patient where you say you know what, I think I need to**

**talk to the physician or somebody else about this particular case. Maybe not quite as bad as the emergency one we were talking about a moment ago, but something where you felt you needed to do more that just enter the note in the system?**

A. Can you repeat your question?

**Q. Yes, because it was not the greatest question in the world. A moment ago we talked about how there can be situations where you look at it and it's a true emergency. Do you recall that?**

A. Yes, sir.

**Q. Are there ever times where maybe it's not an emergency but you still feel the need to go seek out the physician or somebody else to discuss that patient?**

A. Yes, sir, there are times when I've had to do that.

**Q. What kind of situations would cause you to do that?**

A. If the wound is infected or if I'm seeing the eschar is unstable.

**Q. The two we just discussed?**

A. Yes, sir.

**Q. But to confirm, on this here for Exhibit**

**4, you did not see those two things?**

A. I did not, no, sir.

(Exhibit 5 marked for identification.)

**Q. (By Mr. Morgan) We're going to mark Exhibit 5. It should be up on the screen now.**

A. Yes, sir.

**Q. So this is another note but this is the one that is entered by Dr. Papin. Do you see this up here?**

A. Yes, sir, I do see it.

**Q. December 22nd. 7:51. Which if you go back to the previous one that you saw, you saw the patient at December 22nd at just about 11:00 a.m. Do you see that?**

A. Yes, sir.

**Q. So this Exhibit 5, Dr. Papin's note is approximately just over three hours prior to when you saw him, the patient.**

A. Yes, sir.

**Q. It describes how he saw Mr. Newesome today with -- I'm sorry, this is the attending physician, I believe. Do you know who Dr. Batson is?**

A. No, sir.

**Q. But she notates here that she saw**

**Mr. Newesome with the resident today and she agrees with the note. Do you see that?**

A. Yes, sir, I do.

**Q. Were you aware that residents and attending physicians would round to the patients?**

A. I don't know what they do, sir.

**Q. Now it would be fair to say that if Dr. Papin saw this patient about three hours prior to when you saw the patient, that your assessment here in Exhibit 4 would be fairly similar to what Dr. Papin would have seen three hours prior?**

A. I don't know what he would have seen.

**Q. Any reason to believe that what he would have seen would have been way worse than what you saw?**

A. I don't know.

**Q. Can you think of any reason why that would happen?**

A. No, sir, I don't have a reason why.

**Q. Or maybe the opposite way. Is there any reason why you seeing it three hours later it would be way worse than when Dr. Papin saw it?**

A. No, I don't know.

**Q. Fair to say that they should be similar?**

A. I don't know.

**Q. You don't think that the wound and what you are looking at would be similar from three hours before you saw it?**

A. I don't know what he would have seen. I just know what I saw, and what I saw is what I documented there.

**Q. Let me go back to -- I'm sorry, you did answer but let me just confirm. I know I asked you this and I apologize. Here in Exhibit 4, the November{sic} 22nd date you saw the patient. If it was infected, you would have notated that on the record?**

MR. WHITFIELD: I'm going to object to the form. I think you just read the date wrong, that's my only objection. You said November and I think it's December.

**Q. (By Mr. Morgan) Sorry. December 22nd note. If the wound had been infected, you would have notated that?**

A. Yes, sir, if that sacrum wound is infected, I would have notated that.

(Exhibit 6 marked for identification.)

**Q. (By Mr. Morgan) We're showing here what will be marked as Exhibit 6. This is a note that is entered here December 23rd. So that would have**

**been the following day after the record we were just looking at, correct?**

A. Yes, sir.

**Q. It states that patient had been having fevers. Examine, reveals sacral decubitus ulcer wound. It says this patient needs to go to the OR -- which I imagine stands for operating room?**

A. Yes, sir.

**Q. -- today for exploration and debridement. What is debridement?**

A. That's removal of dead tissue.

**Q. This was done by a doctor, this looks like. This was a doctor's diagnosis; is that correct?**

A. Yes, sir.

**Q. Do you know who Dr. Carroll is?**

A. No, sir.

**Q. It reveals a sacral decubitus ulcer. That's similar to what you had diagnosed, correct?**

A. I didn't diagnose it but...

**Q. You assessed it?**

A. Yes, sir.

**Q. It's the same thing you had assessed?**

A. Yes, sir.

**Q. But a day later this doctor felt it was**

**necessary to operate, essentially?**

A. Yes, sir.

**Q. Is that normal in this area of medicine for this type of situation to occur?**

A. I'm not sure.

**Q. Have you ever heard of it happening in a different setting, besides this patient I mean?**

A. I don't recall.

(Exhibit 7 marked for identification.)

**Q. (By Mr. Morgan) We'll mark this last one here as Exhibit 7. I'm going to scroll down here. You can see here -- let me go back up -- that this was a note that was originally entered on December 23rd, 2016?**

A. Yes, sir.

**Q. The date of service there. So that would have been a little bit later in the day that we were just looking at and one day after your last visit to that patient?**

A. Yes, sir.

**Q. If you scroll down to the procedure details.**

A. Yes, sir.

**Q. It talks about how the ulcer is now 10 by 10 centimeters?**

A. Yes, sir.

**Q. Do you see that?**

A. Yes, sir.

**Q. If you go back to Exhibit 4, which was the day before, you had it at four-and-a-half by five centimeters?**

A. Yes, sir.

**Q. Is that normal for an ulcer to grow that rapidly in one day?**

A. I've never seen it grow that rapidly in one day.

**Q. Is it possible that it was larger than what you had notated in this record?**

A. I can't see the wound bed, I can only see the small amount of eschar, the 4.5 by 5.0 amount of eschar, that's all I can see. Because as I stated before, I can't see the wound bed behind the eschar.

**Q. So you believe that this 10 by 10 would have been viewed from underneath the eschar or do you know?**

A. It would have to be underneath it. Because from what we see from my picture it's 4.5 by 5.0.

**Q. And you could see in this note it**

**describes that the ulcer was foul smelling?**

A. Yes, sir.

**Q. But like we discussed, had you smelled a foul smell the day before you would have notated that on the record?**

A. Yes, sir.

**Q. And then it says here there's evidence of grossly necrotic tissue present. Do you see that?**

A. Yes, sir.

**Q. That's why I asked you a few minutes ago if you ever heard the term grossly necrotic. Does this help put in context what I was asking before about that term?**

A. Yes, sir, eschar is necrotic tissue.

**Q. I guess more my question is there's a difference between necrotic and then something that's grossly necrotic or extremely necrotic. Is that an accepted terminology that you use in your field when describing?**

A. I just use necrotic.

**Q. So even if it's the tiniest little bit versus a very, very large amount, you would just write necrotic?**

A. Yes, sir.

**Q. Have you ever seen pressure wounds like this worsen so quickly?**

A. You said have I?

**Q. Have you, yes.**

A. No, sir.

**Q. Have you ever heard of them in any of the literature or other case studies?**

A. I have not read the literature on them.

**Q. Based on your opinion, what do you think happened here with this patient as it kept progressively getting worse?**

MR. WHITFIELD: Object to the form.

**Q. (By Mr. Morgan) You can answer, Ms. Dyse.**

A. I'm not sure. I can only go by what I saw, and what I saw was what's in the picture.

**Q. So the day before on the 22nd when you saw it you didn't notate any foul smell, and you still believe that the proper course of treatment was what you prescribed on that day?**

A. Yes, sir.

**Q. Following this patient -- did anybody ever come to you and discuss the care for this patient?**

A. No, sir.

**Q. This is kind of the first time you've been talking about it since then?**

A. Yes, sir.

**Q. Did anybody ever come to you after the fact and talk to you about Dr. Papin and his role with this patient?**

A. No, sir.

**Q. Fair to say no one has mentioned Dr. Papin to you in several years?**

A. No, sir, no one has ever mentioned Dr. Papin to me except in this encounter.

**Q. When was the first time you found out about this deposition?**

A. When I came to Mr. Whitfield's office.

**Q. You were just told by somebody hey, you need to go to Mr. Whitfield's office?**

A. I spoke with him on the telephone.

MR. WHITFIELD: I'm going to object to what we talked about, but go ahead.

**Q. (By Mr. Morgan) Understood. And I don't want to get into attorney-client communications.**

**Prior to your discussion with Mr. Whitfield had anybody at the hospital or anywhere else, besides Mr. Whitfield, talked to**

**you about Dr. Papin?**

A. No, sir.

**Q. Now during this timeframe -- because you know these records span sort of mid-ish November all the way through December, so roughly a five to six-week period. You saw this patient several times, correct?**

A. I'm sorry. Can you say that again? I just didn't hear the last part.

**Q. That's okay. I asked that during this timeframe you saw this patient several times, correct?**

A. Yes, sir, I believe three times.

**Q. And attending physicians would have also seen this patient, correct?**

A. I'm not sure.

**Q. Do you know if residents would have seen this patient?**

A. I'm not sure.

**Q. Would you agree with me that nurses saw this patient, besides you?**

A. Yes, sir.

**Q. Floor nurses and other assigned nurses to the patient, correct?**

A. Yes, sir.

**Q. And fair to say you would expect that they followed your instructions to change the bandages and the dressings every day?**

A. I just wrote the recommendations. I'm not sure if they follow it or not.

**Q. Is it your experience at UMC that nurses typically do not follow your recommendations?**

A. No, I just write the recommendations and I'm not sure if they follow or not. I'm not sure if they follow.

**Q. Have you ever heard about somebody not following your recommendations?**

A. No, sir.

**Q. We talked earlier about how a doctor can override your instructions?**

A. Yes, sir.

**Q. If that was done, would you expect that to be notated in the patient's file?**

A. I'm not sure, sir.

**Q. Would you expect there would be a doctor note that followed yours saying something different, that as a doctor I'm diagnosing this as this with this treatment?**

A. No, sir, because the only time I would have any other engagement with the patient would

be with another consult. So I wouldn't know one way or another if the doctor had done something different.

**Q. But if you -- if you came back for a second consult?**

A. Yes, sir.

**Q. And in between your first and second consult a doctor had made other orders, would it be fair to say that you would expect to see those orders within the patient's file?**

A. Yes, sir.

**Q. That's what I'm getting at. If there was a time some doctor disagreed with your assessment, it's not just a verbal disagreement, it would be notated in the records?**

A. Yes, sir.

**Q. Do you think anybody is to blame for this patient's care for this ulcer occurring?**

A. I don't know, sir.

**Q. You don't know, no or you just have no idea?**

A. I don't know. I just don't know one way or another.

**Q. Do you know what an ICARE report is?**

A. Yes, sir.

**Q. Do you know if an ICARE report was done on this patient?**

A. I don't know, sir.

**Q. Have you ever been involved in other ICARE reports?**

A. No, sir.

**Q. What is an ICARE report for the record?**

A. To my knowledge it's a computer-based form. We go in and voice our opinions about something that we felt like was done wrong.

**Q. Is that something that you prospectively do yourself or are you requested to complete it or both?**

A. I'm encouraged to do it if I need to do one. I've never done an ICARE report.

**Q. If a patient or a family member of a patient or whatever complains about the care that is given to a patient, typically the hospital is the one to investigate that, correct?**

A. I'm not sure, sir.

**Q. Have you ever been involved in any sort of investigation as to patient care for a patient that you were seeing?**

A. No, sir.

**Q. Have you ever heard of it happening?**

A. No, sir.

**Q. You don't have any personal experience or knowledge from any other wound care nurse of that type of situation happening?**

A. No, sir.

**Q. I believe I asked this earlier but I just want to confirm. After this timeframe that we're talking about, did anybody ever come to you and say that they believed you didn't give sufficient care to this patient?**

A. No, sir.

**Q. From your perspective, you did everything right with this patient?**

A. Yes, sir.

**Q. Let's take another couple minute break.**

(Off the record.)

**Q. (By Mr. Morgan) Ms. Dyse, we kind of talked throughout this deposition about how a doctor can override your assessment and your course of treatment plans, correct?**

A. Yes, sir.

**Q. If that's the case, then all these consults are being ordered by doctors. I guess, why are they reaching out to you for the wound care team to make the assessments?**

A. You say why are they?

**Q. Why are they?**

A. I'm not sure. I guess it's just -- the reasons vary. It kind of helps the physicians to streamline the service. By having us available we could see the wounds and at least make recommendations.

**Q. Be fair to say that this is your world, you see this every day, you've got multiple certifications that you've achieved over the years, you're a pretty authoritative figure when it comes to wounds. Is that a fair characteristic?**

MR. WHITFIELD: Object to the form.

**Q. (By Mr. Morgan) You can still answer.**

A. Well, I just do my job every day. I wouldn't say I'm an authority. Based on my education, I just assess a wound and I make recommendations based on what I see.

**Q. Have you ever heard the term wound care specialist?**

A. Yes.

**Q. Is that another name that they call your position?**

A. Yes, sir.

**Q. So you're a specialist in wound care?**
A. Yes, sir.
**Q. Have you seen some other cases like this where -- notwithstanding the treatment that occur, a pressure ulcer just ultimately somehow develops?**
A. Yes, sir.
**Q. It's something that happens in medicine; is that fair to say?**
A. Yes, sir, it does happen.
**Q. Fair to say you can do all sorts of treatments and sometimes pressure ulcers are just going to happen?**
A. Yes, sir, they happen. Yes, sir.
**Q. Does anyone at the hospital at UMC review your work? Do you get like a yearly review or anything like that?**
A. Yes, sir, we get an annual review. Evaluation.
**Q. Is that your nurse manager who does that?**
A. Yes, sir.
**Q. As part of that review, do they review your -- I don't want to say medical knowledge, that's not the right term I'm looking for. But whether you're doing a good job assessing and**

**treating patients?**

A. They just assess my behavior and how I've carried myself at the job. They don't review patients or anything in the review.

**Q. If a wound care specialist was just, I hate to say this, but just not very good and screwing up, who would be the one who would say look, this person is screwing up and just not a good nurse?**

A. I don't know who -- my manager would contact me, but I don't know who would contact her.

**Q. Do you know if a doctor would?**

A. I don't know.

**Q. Ever heard of that occurring?**

A. I've never heard of it occurring. It hasn't happened to me.

**Q. Fair to say your reviews have been positive?**

A. Yes, sir.

MR. MORGAN: I don't have any more questions.

EXAMINATION BY MR. WHITFIELD:

**Q. I just have a couple of clear-up, just a few small things.**

A. Yes, sir.

**Q. I don't remember what exhibit it was, but when he put up the note of Dr. Papin on December 22nd, 2016; do you remember that exhibit?**

MR. MORGAN: I can pull it up. It was Exhibit 5.

**Q. (By Mr. Whitfield) That was Dr. Papin's note for his view of the patient at seven something in the morning; is that correct?**

A. Yes, sir.

**Q. Is there any reason the record to show where he even examined the wound or made notes of what it looked like on that date?**

A. Not from what I see in front of me, no, sir.

MR. WHITFIELD: Can you scroll through the --

MR. MORGAN: Is this a good speed?

THE WITNESS: Yes, sir, that's a good speed.

MR. MORGAN: This looks like a physical therapist note at this point.

**Q. (By Mr. Whitfield) You've had an opportunity to look at the note there. Was there anything in the note there that showing where he**

**personally examined the wound or his notes of his examination of the wounds?**

A. No, I don't see that there.

**Q. So there's nothing in the record that showed that he even looked at the wound?**

A. Not that I see, no, sir.

**Q. And when you're looking at that wound, that's a late stage decubitus ulcer, right, not an early stage?**

A. That's a late stage, yes, sir.

**Q. And if he would have examined it, you would have expected to see something in the record?**

A. Yes, sir.

MR. WHITFIELD: Nothing further.

EXAMINATION BY MR. MORGAN:

**Q. I'm going to go back to Exhibit 5 here, Ms. Dyse. You see where it says Dr. Batson also saw the patient with the resident today. Do you see that?**

A. Yes, sir, I do.

**Q. Do you see anywhere in this note where Dr. Batson examined the patient?**

A. No, sir, not from what I see there.

MR. MORGAN: No more questions.

(Time Noted: 3:45 p.m.)

SIGNATURE/NOT WAIVED

ORIGINAL: MR. MORGAN, ESQ.

COPY: MR. WHITFIELD, ESQ.

CERTIFICATE OF DEPONENT

DEPONENT: KISHA DYSE
DATE: November 16, 2020
CASE STYLE: Papin vs. UMMC
ORIGINAL TO: Mr. Morgan, ESQ.

I, the above-named deponent in the deposition taken in the herein styled and numbered cause, certify that I have examined the deposition taken on the date above as to the correctness thereof, and that after reading said pages, I find them to contain a full and true transcript of the testimony as given by me.

Subject to those corrections listed below, if any, I find the transcript to be the correct testimony I gave at the aforestated time and place.

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This the ____ day of _____, 2020.

_____
KISHA DYSE

State of Mississippi
County of _____

Subscribed and sworn to before me, this the _____ day of _____, 2020.

My Commission Expires:

_____ _____

Notary Public

CERTIFICATE OF COURT REPORTER

I, Robin G. Burwell, Court Reporter and Notary Public, in and for the State of Mississippi, hereby certify that the foregoing contains a true and correct transcript of the testimony of KISHA DYSE, as taken by me in the aforementioned matter at the time and place heretofore stated, as taken by stenotype and later reduced to typewritten form under my supervision by means of computer-aided transcription.

I further certify that under the authority vested in me by the State of Mississippi that the witness was placed under oath by me to truthfully answer all questions in the matter.

I further certify that, to the best of my knowledge, I am not in the employ of or related to any party in this matter and have no interest, monetary or otherwise, in the final outcome of this matter.

Witness my signature and seal this the 30th day of November, 2020.

Robin G. Burwell

ROBIN G. BURWELL, #1651
CRR, RPR, CCR

My Commission Expires:
April 6, 2021